DSS-284
(R.4-87)

Commonwealth of Kentucky
Cabinet for Families and Children
Department for Community Based Services

COMPLAINT REPORT

TO : Division for Licensing and Regulation Date _____

FROM: _____
(Worker)

_____
(Local Office)

Type(s) of Facility If telephone call made; date _____

____Family Care Home
____Personal Care Home
____Intermediate Care Facility
____Skilled Nursing Facility
____Other _____
(specify)

1. RE: Name of Facility: _____
   Address: _____
   (Street) (City) (County)
2. Source of Complaint (If other than originator of form): _____

   Date Complaint Received by DSS: _____
3. Description of Complaint: _____